WORLD HEALTH ORGANIZATION (WHO) : STRATEGY ON MEASURING RESPONSIVENESS

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1. Introduction

This paper describes the World Health Organisation (WHO) strategy for the measurement of responsiveness, one of the three intrinsic goals of health system performance measurement. Responsiveness is how well the health system meets the legitimate expectations of the population for the non-health enhancing aspects of the health system. It includes seven elements: dignity, confidentiality, autonomy, prompt attention, social support, basic amenities, and choice of provider.

The paper begins by putting responsiveness in the context of the other two intrinsic goals, health and fair financing. Since responsiveness is comparatively new, the paper elaborates on the rationale for responsiveness sharing the elevated status of an intrinsic goal.

The WHO strategy is designed to: (1) achieve a clear understanding of the conceptual framework of responsiveness to guide the development of responsiveness measures and improvement and (2) develop reliable and valid measures of responsiveness; (3) keep the costs and burden of responsiveness data collection as low as possible and (4) link the measurement of responsiveness with its improvement.

2. Responsiveness within Context of Health System Goals

2.1. *Responsiveness as an Intrinsic Goal*

The WHO framework for health systems performance assessment begins by addressing the simple question: What are health systems for? [1] The obvious answer to this question is that they are for improving and maintaining the health of the population. Thus, health is the defining goal of health systems. However, an equally compelling answer to the question is that health systems are for meeting the needs of the people they serve. Meeting these needs is the intrinsic health system performance goal that WHO calls responsiveness.

The three intrinsic goals are:

- Health – To improve and maintain the health of the population

- Fair financing and financial risk protection – To assure that households do not become impoverished or pay an excessive share of their income in obtaining needed health care

- Responsiveness – To enhance the responsiveness of the health system to the legitimate expectations of the population for non-health enhancing dimensions of their interactions with the health system.

When measuring health and responsiveness it is important to measure both the level of achievement (average over the whole population) as well as the distribution (equitable spread of this achievement to all segments of the population).

Responsiveness as an intrinsic goal has the following values:

- It can be raised without affecting the other intrinsic goals. It is at least partially independent of the other intrinsic goals.

- There is merit in improving responsiveness even if the other intrinsic goals are not affected. Improvement of the well-being of the person is an important goal of the health system. It is desirable to raise it, in and of itself. Not to raise responsiveness is undesirable.

2.2. *Understanding Responsiveness*

WHO is introducing the term responsiveness with the release of the World Health Report. However, it is grounded in an established body of research, from which common defining factors of responsiveness emerge.

In addition to making and keeping them healthy, consumers say that the health system should treat them with dignity, facilitate their role in decisions about their care, provide for clear communication with their health care providers and assure that their medical encounters are kept confidential [2]. These health system actions form the cluster within responsiveness known as respect for persons. Consumers have also called for the systems to provide prompt attention, access to social support, choice of provider and basic amenities of adequate quality. These form the cluster called client orientation [2].

Another way of looking at responsiveness as a measure of health system performance is to compare it to health measures. When assessing health one looks at health outcomes or reviews the clinical processes of care or health systems' disease prevention and health promotion programs. With the current state of the art in measuring responsiveness, one asks consumers within the health system to report on their experience with elements of care and other health system services that are as much measures of system performance, as are health measures. Responsiveness is based on consumers' reports on those factors (respect for persons and client orientation) that they care about and about which they are the best source of information.

There is evidence from developed countries, that satisfied patients are more likely to comply with medical treatment, provide relevant information to their health care provider and continue using medical services [3, 4]. In developing countries it has been observed that patient satisfaction will influence utilisation of services and compliance with practitioners' recommendations [5, 6, 7]. But, we also know that responsiveness is important for its own sake, regardless of its impact on health. Within the WHO framework for assessing health system performance, the measurement of responsiveness is confined to those elements that relate to the individual's well-being and do not account for any health enhancing aspect. This is done so as to measure the achievement of the responsiveness goal apart from its impact on achieving the health goal.

The argument that health is all that matters falters because there are ways to improve health that would do serious harm to people's well-being. For example, one could improve health by locking people up who have a communicable disease. That is not an acceptable solution. It may protect part of the population but at the cost of incarcerating the rest.

2.3. *The Importance of Responsiveness*

Beyond its status as an intrinsic goal, responsiveness is important for a number of reasons.

a. Addressing the legitimate expectations of people is at the heart of the stewardship function of health systems. For example, in its stewardship role, the health system has a major responsibility for maintaining a level playing field among the actors in a health system. Consumers are usually at a disadvantage in dealing with producers of health care and need the health system to help them level the playing field by providing them information and protection [1]. Facilitating the effective flow of information between the health system and the population is a key element of responsiveness. This information is an excellent tool for the stewards of the system to use to address the imbalances that generally exist.

b. Responsiveness is fundamental, because it relates to basic human rights. Health systems, education, economic, political and cultural systems share responsiveness as a goal. Each system to be successful must respond to the legitimate needs of its constituents. At the core of this shared responsiveness goal is protecting and enhancing the population's basic human rights. To not address responsiveness within the health system would be denying this shared responsibility.

As part of the research for developing the scoring system for the three intrinsic goals, WHO conducted a survey on its website. Respondents were persons who used the site and chose to answer the survey and included both WHO employees and others from outside WHO. The expectation was that respondents would give much the heaviest weight to health. There was remarkable consistency between the two groups of respondents in rating the importance of the three intrinsic goals. Respondents indicated that health should receive 50% of the weight, fair financing 25% and responsiveness 25% [8]. The importance placed on the responsiveness was borne out by these results.

c. A health system can improve some of the elements of responsiveness without large investments. In particular, improving the respect shown for persons in the system may require significant changes in the attitude of health system personnel towards their constituents, but a minimal investment of funds. For example, training health care staff to be more responsive to the basic right of individuals to be treated with dignity requires a minimal expenditure of money. Making important improvements in responsiveness also does not necessarily entail a major investment in technology or staff that making improvements in health may. Improving responsiveness may not necessarily require new legislation to authorise it, as changes in fair financing may.

However, not all changes in responsiveness are low in cost. Addressing the client orientation elements of responsiveness, such as choice of doctor or prompt attention, may require the application of additional resources to be fully realised. But, in general a health system can make measurable progress in responsiveness without major investment of funds.

d. Improvements in responsiveness may come before changes in performance on either of the other two intrinsic goals. Because it does not require a major investment and

because the results of interventions to improve it may show quick results, responsiveness can be improved much faster than health. For example, an improvement in whether staff in clinics treat persons with respect may be reflected quickly in persons' responses to a survey about responsiveness much faster than changes in behaviour lead to improvements in health.

There are two notes of caution: (1) quick fixes designed to "bump up" responsiveness scores without an effort to realise long term change, will not result in sustained improvement in responsiveness performance. Initial efforts must be followed by fundamental changes in the way the system responds; and (2) improvements in responsiveness will not necessarily lead to improvements in addressing the health and fair financing goals. While chances of attainment of these goals may be enhanced by improved responsiveness, the health system needs to address each intrinsic goal. One would expect a system that is responsive to the legitimate needs of its people for respect and client orientation to also seriously address improving health and fairness in financing. But, sustained change across all goals requires a multifaceted strategy designed to address all three goals continuously but not necessarily simultaneously.

In short, the intrinsic goal of responsiveness is important because it deals with basic human rights of individuals, reflects a positive orientation to those the system is designed to serve and holds promise for meaningful improvement to be made in the well-being of the population. The objectives and components of the WHO strategy for achieving responsiveness in health systems are described in the sections that follow.

3. WHO Strategy – Objectives

The WHO strategy for measuring responsiveness is designed to achieve these objectives:

Provide a clear conceptual framework for responsiveness – Compared to measuring health status and outcomes, measurement of responsiveness is new as a measure to most health systems. Therefore, the conceptualisation of responsiveness must not only be well grounded in the measurement of its underlying factors, it must also be communicated clearly.

Measure responsiveness reliably and validly – With our current ways of measuring responsiveness, those who are served by the health system report on how they were treated. Therefore, measurement depends on getting reliable and valid reports from people of varying cultures, levels of education, experience with the health system and levels of expectation.

Keep the costs and burden of collecting data on responsiveness as low as possible - Measuring responsiveness entails primary data collection. Therefore, the strategy must be to get the maximum benefit from the least expenditure of funds.

Link the measurement of responsiveness with its improvement – The ultimate objective of the WHO framework for health system performance assessment is to help health systems improve their performance. The strategy for responsiveness includes an approach for getting from measurement to policies for improvement.

4. WHO Strategy - Approach

The WHO has a strong commitment to the implementation of the strategy for measuring responsiveness. This strategy, however, is still evolving. The importance that WHO places on responsiveness is reflected in its decision to explicate the strategy now, before all of the implementation steps have been fully determined. There are a number of challenges that implementation faces. The approach to addressing these challenges is described below.

The strategy includes as a key component active participation by member countries and regions in the implementation and further refinement of the strategy in order to meet these challenges. Only, through that active participation can the goal of responsiveness be achieved.

4.1. *Provide a Clear Conceptual Framework for Responsiveness*

A good deal of previous research has addressed respect for persons and client orientation. The responsiveness elements are drawn from that research [2]. The elements as they are currently structured are shown in Appendix 1.

As the strategy is implemented and further data are gathered, WHO will review the current framework of the elements of responsiveness to assess whether refinements are warranted. However, the fundamental meaning of responsiveness is established and will not be altered materially. It is important from a measurement standpoint to arrive at a clear set of factors, which define responsiveness.

The greater challenge is explaining what "responsiveness" is to health system policy makers, consumers and health care providers. To write a clear explanation depends first on a clear and sound construct about which to write. However, communicating the construct goes several steps further. Research described earlier, established that these responsiveness elements are those that consumers value when thinking about what they want their health system to do for them. Therefore, for consumers, these elements have face validity. Explaining responsiveness to policy makers and providers may be more difficult.

In thinking about responsiveness we can posit these two measurement objectives:

- One objective is to measure **what happens** when a health system and the persons it serves interact. This objective seeks to report the behaviour, event or action of the health system. That is, measure what happens.

- Another objective is to measure a **person's perception of what happens**. This objective deliberately attempts to measure how the persons served by the health system perceive "what happens" and asks for the person's evaluation of what they perceive.

WHO's strategy for measuring responsiveness focuses on the first of these when measuring and reporting the performance of health systems on responsiveness. WHO's

objective is to measure the responsiveness that took place in a health system. That is, to measure what happened.

However, WHO is also interested in the second objective. As policy makers, attempt to implement health systems that are responsive to the people they serve, it is important to understand the perceptions of those people. One segment of the society may have the perception that the health system is not responsive to them; even though measures of "what happens" indicate otherwise. Policy makers need to assess what factors are contributing to this perception and to address them appropriately.

In understanding what is meant by responsiveness, one challenge is to distinguish it from what has been called , "patient satisfaction". Responsiveness is distinct from patient satisfaction in three main ways:

- Scope- patient satisfaction usually focuses on clinical interactions in specific health care settings, whereas responsiveness evaluates the health system as a whole

- Range - patient satisfaction generally covers both medical and non-medical aspects of care while responsiveness focuses only on the non-health enhancing aspects of the health system

- Rationale - patient satisfaction represents a complex mixture of perceived need, individually determined expectations and experience of care. Responsiveness evaluates individual'' perceptions of the health system against "legitimate universal expectations."

Responsiveness measurement moves away from finding out whether a person is satisfied with their care toward more reporting of the experience of the person with the health system. Individuals are also asked to rate their health system against objectively set standards of universally legitimate expectations [2].

The World Health Report is the first time the term responsiveness has been used in this way. Only through its continued use and testing will a better understanding be developed. WHO will work with its regional offices and member countries to continue to improve the understanding of this important intrinsic goal. Described more fully later is the development and use of a network of persons interested in responsiveness in the regions and member countries that will assist in explaining the construct to policy makers.

4.2. *Provide for Reliable and Valid Measurement*

The WHO strategy draws on a rich body of research and includes several approaches to optimise the reliability and validity of the responsiveness measurements. These include: use of reports and ratings scales; a combination of cognitive and field testing of instruments; determining the role of importance ratings of the elements; assessment of the distribution of responsiveness; validation of respondent reports; measuring variables outside of personal health services; coordination with a network of persons in the regions and countries where data will be collected and ongoing research and documentation to continue to improve techniques.

a. Use of reports and ratings. The ideal tool to implement measurement would be free of error and would faithfully reproduce either what happens or the perception of what happens. Unfortunately, no error free device exists. Therefore, we use the tools we have that rely on people to observe and report on what happened and try to validate their reports.

WHO in its responsiveness strategy is implementing measurement tools that provide as close a report of what happened as possible. The strategy includes reports from those who are served by the health system and methods for assessing how those reports compare with other observations of what happens.

The WHO strategy is to measure the consumer's reports and ratings of the experience with their care, rather than their satisfaction. An example may serve to illustrate the difference. Below is an item from a WHO responsiveness instrument asking the respondent to report on their experience with care and an item asking about a similar experience, but asking for a rating of satisfaction:

> **Responsiveness Report Item**: In the last 6 months how often did doctors, nurses or other health care providers at [name of health care unit] explain things in a way you could understand ? [Scale: Never, Sometimes, Usually, Always]
>
> **Satisfaction Item:** In the last 6 months how satisfied were you with how well doctors, nurses, or other health care providers explained things in a way you could understand? [Scale: Very dissatisfied, Dissatisfied, Satisfied, Very satisfied].

The **responsiveness report item** asks for the respondent's perception of the frequency with which things were explained in a way she/he could understand. It is designed to be much less influenced by what the respondent expected regarding how well things would be explained. The respondent may have expected things to **never** be explained or to **always** be explained. But, he or she is being asked to report on what actually happened, from his/her perspective.

The **satisfaction item** asks the respondent to tell how satisfied she/he was. The respondent's level of expectation is brought into play. If the respondent expects poor communication she/he may well rate satisfaction with communication differently than one who was expecting better. The satisfaction items call for the respondent to filter their assessment of the experience through the expectations that they bring to the task.

The responsiveness surveys also include ratings of the elements of responsiveness on a 0-10 scale. For example:

> Using any number from 0-10, where 0 is the worst score and 10 is the best score, how would you rate [name of health care unit] on how well doctors, nurses or other health care providers communicated with you?

The rating items require the respondent to evaluate the experience in the context of the sub-elements of responsiveness. A respondent's level of expectation is likely to play some role in the respondent's formulation of an answer. However, the rating items are

distinct from satisfaction items in that they do not ask the respondent to say how satisfied they were.

Another important advantage of the report and rating items over satisfaction items comes in measuring changes over time. As health systems change over time, either up or down, the level of expectations are likely to move up or down accordingly. Under these conditions, report items are likely to more consistently reflect what is happening than satisfaction items.

Satisfaction measures are designed to measure how well the health system lived up to expectations. What may result is that people who are treated worse lower their expectations and may be satisfied with lower levels of performance. But, the health system has not responded to their universal legitimate expectations. Therefore, patient satisfaction measures may well erase differences in the responsiveness being experienced by those to whom the system is least responsive and those to whom it is most responsive because the former group has learned to lower its expectations to meet the level of services it is getting [9].

Also, the general experience with satisfaction items are that they tend to yield high levels of satisfaction with care that do not match with reports of experiences or problems with that same care. There is some evidence that reports from patients reflect more negative assessments than do satisfaction items [10].

b. Cognitive and field testing. The responsiveness surveys will be conducted in multiple countries with different cultures and health systems. Survey questions need to be posed in a way that facilitates as consistent an interpretation of the meaning of the items as possible across countries, cultures and health systems.

The WHO strategy will employ an approach that will combine cognitive and field-testing. These two techniques, used jointly, provide the best evidence on the reliability and validity of the instruments as well as guidance on how to revise them for future use. The objective is to design a survey that will gather data in a cost -effective manner and address measurement error along with other sources of error, including sampling and non-response [11, 12].

Cognitive testing is a technique designed to assess how respondents understand and interpret questionnaire items presented to them, how they recall information that applies to the question, the judgments they make as to what information to use and how they form a response [13].

The two most frequently used cognitive testing techniques are the "think aloud" interview and debriefing. In the think aloud procedure, respondents say out loud what they are thinking about with regard to the questions they are answering what the questions mean to them, what information they are drawing upon to answer the questions and how they are forming their responses as they complete the questionnaire. Interviewers may probe to get the respondents to elaborate or clarify. In debriefing, interviewers ask respondents to provide similar information; but after they have completed the questionnaire.

Investigators review the comments that are made and identify item wording, instructions and formatting that may cause the respondents to interpret the items in a way that is different from what was intended by the investigators. These techniques may provide clues as to how the items might be revised in order to arrive at an interpretation that is consistent with what was intended [14, 15].

Field tests are then used to test the instrument, try out data collection and sampling approaches and get estimates of the instruments reliability and validity. Field testing alone does not provide an evaluation of whether respondents are interpreting questionnaire items as intended. However, cognitive testing and field-testing together will provide the guidance needed to improve the reliability and validity of instruments.

WHO is designing a series of protocols to be used for cognitive testing in the countries where responsiveness surveys are to be fielded. We will draw on the expertise of survey methodologists and medical anthropologists to help evaluate the design and testing of the instruments to address the differences in cultures. We also, will draw on the responsiveness network at the regional and country level to help us address the cultural and health system differences.

c. Determining the role of importance ratings of elements. The elements of responsiveness may not all be of equal importance. Respondents in the survey of health professionals described earlier [8] were asked to rank the seven elements of responsiveness on the basis of how important they are. Their rankings in decreasing order of importance were: prompt attention; dignity; autonomy; confidentiality; social support networks; basic amenities and choice of care provider. The differences in the relative weights given to the elements were not large.

We seek to assess these rankings in the upcoming responsiveness household surveys. Respondents will be asked to rank the elements by importance. Cognitive testing will be conducted to assess their interpretation of both the elements and the meaning of "importance". Alternative approaches to getting response on importance will also be tried.

d. Assessment of distribution of responsiveness. A substantial amount of work needs to be done to refine the measurement of the distribution of responsiveness. Currently, the measure is based on identifying vulnerable groups and assessing responsiveness for them versus non-vulnerable groups. While it will remain important to assess responsiveness across different groups in society, the measurement of the total inequality in a population, as is being developed for health [16], promises to be the most comprehensive approach to measuring inequality in responsiveness. Individual reports on responsiveness obtained from household surveys will be needed to estimate inequality across the population. With this approach, the distribution of responsiveness around each of the elements will be explored. Future research on the importance weighting of different elements is also planned to consider whether inequality in different elements is weighted differently. The methodology used in the World Health Report 2000 implicitly gives equal weight to distribution across elements [17, 18]. While the WHO plans to extend the household survey to other countries in the future, the near term approach will use data from the key informant surveys for evaluating distribution. Therefore, it will be

necessary to refine the evaluation of distribution and identify better explanatory variables for modelling responsiveness.

e. Validation of data. Data used to measure responsiveness will come from those who are served by the health system responding in the household surveys. These data represent the perception of the respondents reporting on and rating their care. It is useful to gather data from other sources to assess whether there are any systematic differences in the data collected from household respondents which do not vary with differences in the health system's responsiveness. The WHO strategy employs an affordable approach to validating household survey data that will facilitate identifying any significant non-substantive variations in the data which might materially affect the results and provide guidance for adjusting for those systematic variations.

A sample of health care units named by respondents in the household survey will be surveyed in order to validate household responses. The purposes of the validation are:

- To provide data on the physical characteristics of the facilities and processes of care in order to compare them to household respondents' data. For example, from observation and interviews with staff, data will be gathered on the physical setting in which examinations and consultations are carried out to compare data on these characteristics to respondents' reports of whether consultations were carried out in a way that maintained confidentiality.

- Through interviews with staff and patients exiting the facilities, data on responsiveness that can be collected and compared to those provided by household respondents.

Analyses of these data will allows us to assess whether respondents with any particular characteristics have perceptions that consistently deviate from what is observed in the facility survey.

The facility survey will allow an assessment as to whether the systematic differences affect the "report" items as much as they affect the "rating" items. The report items are thought to be more objective and less vulnerable to expectations. The survey provides an opportunity to test this hypothesis more thoroughly.

The WHO strategy will also include seizing opportunities in countries which are conducting surveys that are measuring similar variables to compare their results to those of the WHO responsiveness surveys. In doing this, consideration must be given to the differences in survey questions, purposes, sampling framework and timing. Given reasonable comparability, such surveys could provide an external assessment of the validity of the WHO responsiveness surveys. In addition, if the results produce comparable results, countries' ongoing surveys may provide alternative sources of data to the WHO surveys on responsiveness.

f. Measuring variables outside of personal health services. A key underpinning of the WHO framework is that it relates to the entire health system, not just to the delivery of personal health care services. Unfortunately, in the area of responsiveness the bulk of the research that has been done in assessment of health services has focussed on personal

health care. In the current version of the household questionnaire, there has been an attempt to broaden this scope to include public health services but more work needs to be done on this in the future.

An added difficulty is that respondents are probably more easily able to form the referent when asked about their personal healthcare and where they get it, than when you ask them about the "health system". They may not have a ready referent in mind that means "health system" to them. We will use the opportunity to conduct some cognitive interviews in the household survey to probe on the best way to get respondents to think about the health system as a whole.

g. Network with regional offices, country representatives and focal persons. It has been obvious from the beginning that the success of measuring responsiveness will depend on getting help from people in countries where responsiveness surveys will be administered and from WHO staff, particularly those who are knowledgeable about human right issues and health systems. This help is needed during the developmental stage to get feedback on how well instruments and procedures are likely to work. It is also needed as the surveys are implemented to provide help in locating agents to conduct the surveys and assist coordinating the surveys.

Last November WHO conducted a survey of key informants knowledgeable about their countries' health systems. Focal persons were identified in 35 countries who then selected and coordinated data collection from about 50 key informants in each country. The focal persons attended a meeting in December where the results of the survey were discussed. Contact has been maintained with them over the intervening months.

In addition, the WHO framework for health system performance measurement was presented to a group of WHO regional office staff and country representatives in Harare in April. There was considerable interest among the group in responsiveness and several offers to help as the responsiveness strategy is implemented.

WHO has a website to help to facilitate communication among WHO staff developing and implementing responsiveness measures and persons in the regions and countries where the survey will be administered.

We have also been coordinating development of the surveys with appropriate staff at WHO.

h. Papers and experts and stakeholders meeting. While measurement in the area of responsiveness is relatively new, a good deal of research is currently being planned for this area. It is planned to have a series of papers prepared to address the important methodological challenges faced in measuring responsiveness and hold a meeting where these papers will be presented and discussed by methodological experts and stakeholders who will be implementing the responsiveness measurement tools. The focus of these papers and the meeting would be to address the practical issues that countries face as they implement the WHO strategy. Papers would include such topics as:

- Operationalising the elements of responsiveness
- Operationalising the distribution aspects of responsiveness

- Proven techniques for achieving reliable data on responsiveness
- Proven techniques for cost effective data collection.

4.3 *Keep Costs and Burden as Low as Possible*

The WHO strategy for measuring responsiveness calls for substantial primary data collection. A household survey with in-person interviews will be conducted in 10 countries this year with samples varying from 5000-10,000 households per country. The facility survey will be conducted to validate data from the household survey.

In addition, WHO is exploring the feasibility of conducting household surveys conducted by post in an additional 50 countries and the key informant survey in as many countries as possible.

The purpose, likely sample size, mode of data collection and domains on which data will be collected are summarised in Appendix 2.

The costs associated with these data collection exercises may be substantial. Therefore it will be important to try to reduce costs in future years to the degree possible. With that in mind, the WHO strategy incorporates several innovations to reduce costs of the surveys now and in the future.

a. Development of brief modules. A number of the costs associated with conducting surveys vary with the length of the questionnaire. The longer an interviewer-administered questionnaire the greater the interviewer costs. Longer postal surveys may cost more for postage and may yield lower response rates, requiring greater follow-up and more cost than shorter instruments.

The current surveys listed above are expected to be fielded this year. Data will be used from these surveys if the results prove reliable. In addition, as part of this fielding, the instruments will be evaluated through psychometric analysis and cognitive testing. The purpose of this testing will be to improve the instruments ability to provide the data required for measuring responsiveness in a reliable, valid and cost-effective manner. Analysts will review factor analyses on each instrument to assess where items might be eliminated. These analyses are designed to uncover items that may not be contributing enough unique information to warrant keeping them. Also, since this is the initial use of these instruments, additional variables are included for purposes of studying what factors might influence responsiveness or contribute to more accurate reporting. Once this initial phase is over, it may be possible to drop such items. For example, a number of variables are included in the facility survey about the characteristics of the facility which potentially may affect how responsive a facility is. Once it is determined which of these characteristics influence responsiveness, the others may be dropped.

Thus the goal will be to develop a strong, parsimonious set of items in the case of each survey. One additional goal would be to produce modules on responsiveness that could be inserted in existing surveys conducted in countries on nationally representative samples. This would allow the responsiveness surveys to piggyback on other surveys and incur only marginal costs. WHO will be kept informed on what surveys member

countries may be planning and whether they might be able to be supplemented with responsiveness items.

b. Flexible data collection strategies. Large-scale household data collection, if done in-person, would be quite expensive. The WHO is considering introducing the use of postal surveys in countries where the postal system and literacy levels will make them feasible. Postal surveys are much less expensive than in-person surveys, although they are not likely to yield high response rates. The potential cost reduction with postal surveys is likely to be substantial enough to make them a more feasible option over time. During the next year WHO is considering fielding a postal version of the household survey in as many as 50 countries. Response rates, data collection issues such as accuracy of addresses and promptness of delivery and costs will be evaluated. In addition, in 10 percent of the 5000-10,000 households in at least some of the 10 countries fielding the in-person household survey, respondents will be asked to complete a self-administered version of the household questionnaire. Results from these questionnaires will be compared to those that were administered in-person to evaluate whether the mode of administration affects the responses given. Depending on how these tests turn out, it may be possible to supplement in-person household surveys or possibly replace them in some countries with postal surveys.

c. Surveys at multiple levels – Overlapping countries. A basic principle underlying responsiveness measurement is that the people served by the system are the best source of information about their experience relative to responsiveness. However, it is not practical to administer a household survey in every country. As indicated, the planned data collection will include key informant surveys that are conducted in the same countries in which the household in-person and postal survey will be done. This will facilitate an analysis of the association between data from household respondents and key informants. If a clear picture of the relationship between the results of these surveys emerges then it may be possible to use the much less expensive key informant survey in countries where no household data are available. It should be underscored that data from key informants are not data from those the health system serves. But, until we know what relationship exists between the responses from key informants and household respondents we cannot assess how well the key informants survey might help us fill the gaps where we would otherwise have no data.

d. Secondary indicators. In addition to the surveys described here, WHO will explore the possibility of collecting secondary data. One useful source of secondary data is the media of each country. Analysis of the press and electronic media holds the potential to provide useful information on changes that may take place regarding responsiveness either countrywide or within a particular sector or health care unit. Reviewing what is written in the media may help identify indicators regarding responsiveness such as: submission of legislation to protect patients rights; changes in policy designed to make the health system more responsive, inclusion of responsiveness elements in regulation for health care, training of doctors to communicate better with patients, advertising that emphasises responsiveness as attributes of health care facilities.

We also propose to look at results from country surveys that may include responsiveness or responsiveness-like items coupled with an ongoing monitoring of the literature related to responsiveness.

e. Patient charters and legislation. WHO is undertaking an analysis to determine which countries have adopted patient charters or other legislation that is designed to address responsiveness issues. This analysis may provide a view of macro-level changes in a country relative to responsiveness.

4.4. *Building a Bridge from Measuring Responsiveness to Improving It*

The WHO framework for measuring health system performance describes the functions of the health system and how they relate to improving systems performance. The purpose behind measurement of performance is to prepare the foundation for making improvements. The WHO strategy for measuring responsiveness includes several features which will help with this process.

a. Guidance from responsiveness results. The responsiveness household surveys are structured so that there are clusters of questions about each of the seven elements that make up responsiveness. First, respondents are asked to report how frequently a set of specific behaviours that comprise the particular element have occurred in their interaction with the health care unit they go to most often for care.

For example for **dignity**, respondents are asked the following three questions:

- In the last 6 months, when you went to [name of health care unit/provider's office] how often did doctors, nurses or other health care providers treat you in a respectful way? (Never, Sometimes, Usually, Always)
- In the last 6 months, how often did office staff, such as receptionists or orderlies, at [name of health care unit/provider's office] treat you respectful way? (Never, Sometimes, Usually, Always)
- In the last 6 months, how often were physical examinations and treatment at [name of health care unit/provider's office] provided in a way that ensured your privacy? (Never, Sometimes, Usually, Always)

These specific behavioural questions within an element are followed by a request for the respondent to rate the health care unit or provider's office on that element. For example for **dignity**, people are asked:

- Now, using any number from 0-10, where 0 is the worst and 10 is the best, how would you rate [name of health care unit/provider's office] for the dignity with which you were treated? (0-10)

The rating item will be used in the calculation of a country's responsiveness score. The combination of these two types of questions for each of the responsiveness elements also provides guidance to countries on where to look to try to improve the responsiveness of their health systems. Therefore, if one looks beyond the overall score to the individual element scores, and then to the results on the specific behaviour reports there is a story to be read about where improvement efforts might be placed.

Taking the example presented above for dignity, a hypothetical country's results on these questions may look like this.

- Average rating on dignity is 4 on the 0-10 scale. This was the country's lowest element score.
- Frequency with which doctors, nurses or other health care providers treat persons with caring and respect (10% Never; 15% Sometimes; 45% Usually; 30% Always)
- Frequency with which office staff treated persons with caring and respect (35% Never; 45% Sometimes; 15% Usually; 5% Always)
- Frequency with which physical examinations and treatments were provided in a way that ensured privacy. (20% Never; 35% Sometimes; 30%Usually; 15% Always).

The results from this hypothetical example suggest that, overall the country is doing poorly on dignity. The rating of 4 reflects this. The reports on specific behaviours included in dignity give some guidance regarding which behaviours may be contributing to this low score. Responses to the first question about doctors, nurses and other health care providers reflect reasonable responsiveness. Seventy-five percent of respondents were treated with caring and respect usually or always. Responses to the same question about office staff reflect a different story. Only twenty percent of respondents were treated with care and respect usually or always. The third question suggests a similar unfavourable outcome as the second, though not quite as extreme. Here 45% of respondents indicated that physical examinations or treatments were usually or always carried out so that their privacy was ensured. These results suggest areas which policy makers in the country may want to focus on. WHO plans to provide guidance on how to interpret and use these results on its website and in a workbook which are both described later.

b. Building a constituency. Earlier we described the creation of a network of persons in the regions and countries who will work with us as we implement the responsiveness surveys. We will ask this same network to help us find effective strategies for improving responsiveness based on the results from the surveys. This group will assist in developing a workbook that provides helpful information on how to get from responsiveness measurement to improvement at the regional and country levels. The workbook will help countries to use the results of the responsiveness survey to determine what next steps to take to strengthen areas of responsiveness where improvement is needed. Descriptions of countries that have successfully strengthened responsiveness will be included.

An important tool for this network will be the website which has recently become operational and will provide access to new responsiveness measurement and improvement tools. The website will allow countries in similar circumstances to trade information on how best to address areas of responsiveness needing improvement.

c. Calibration – Overlapping countries – surveys at multiple levels. Our survey strategy involves using the four surveys mentioned earlier. The first two surveys are with household respondents, one done in-person in 10 countries and the other done by post in

as many as 50 countries; the third is a survey of a sample of outpatient and inpatient health care units and or providers that are identified by household respondents, and the fourth the survey of key informants.

The plan is to conduct the two household surveys and the key informant surveys in some of the same countries. This will allow us to assess the responses provided by key informants and household respondents to determine if there are any stable relationships between the survey results, which allow for modelling the inter-relationship. This might allow for more stable projections that facilitate their use in efforts to improve responsiveness.

d. Trending. It will be useful for countries to be able to track changes in performance over time as improvement programs are introduced. The strategy includes building databases to support trend analysis. It will be particularly important to accommodate changes in the questionnaires overtime as they are refined and shortened.

4.5. Conclusion

The WHO strategy presents an integrated approach for collecting and using data for measuring and improving responsiveness. The strategy is built on a strong research base and is drawing on stakeholders to provide input and guidance. Given the importance of learning more about responsiveness and how to measure and improve it in member countries, it is critical to get a spirit of collaboration to move the responsiveness program forward. This strategy is presented as WHO's approach to achieving one of its intrinsic goals. It is still in its early stages. Participation by all those affected and interested is enthusiastically encouraged.

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Appendix 1: Responsiveness Elements

Dignity

- Individuals should be treated with respect: welcomed at the health care unit, addressed respectfully at all times, not shouted at or abused.
- Individuals should be treated with concern
- Individuals should be examined and treated in a manner that respects their privacy.
- The rights of Individuals with communicable diseases such as HIV+ and leprosy or any other type of diseases should be safeguarded and not violated

Autonomy

- Individuals should be told about alternative treatment options
- Individuals should be allowed to make decisions regarding the type of treatment, after discussion with the health care provider
- Individuals should be encouraged to question
- Patients of sound mind should have the right to refuse treatment.

Confidentiality *(of information)*

- Consultations with patients should be carried out in a manner that protects their privacy.
- Health care providers should maintain the confidentiality of any information that is provided by the patient (except if the information is needed for treatment by other health care providers*).*
- Health care providers should keep information in patient medical records confidential (except where such information needs to be given to another health care provider).

Prompt Attention

- Health care facilities should be geographically accessible – taking account of distance, transport, and terrain.
- Patients should be able to get care fast in emergencies.
- Waiting times for consultation and treatment should be short.
- Waiting lists for consultation and treatment should be short.
- Waiting times for appointments should be reasonable.

Provision of Social Needs

Procedures within in-patient health care units should allow

- Visits by relatives and friends
- Provision of food and other consumables by relatives and friends, if not provided by the hospital
- Religious practices that do not prove to be a hindrance to hospital activities or hurt the sensibilities of other individuals
- Access to radios, newspapers or some reading materials
- Some type of support for patients suffering from on-going illness or illnesses from which they will die
- Post-hospital support.

Basic Amenities

Environment in which health care is provided should include*:*

- Clean surroundings
- Adequate furniture
- Healthy and edible food
- Sufficient ventilation
- Clean Water
- Clean toilets
- Clean linen
- Regular procedures for cleaning and maintaining hospital buildings and premises

Choice of Provider Doctor/Nurse/Care Provider or Facility

- Patients should be able to reach health services of choice without to much difficulty
- Within a health care unit individuals should be able to choose their health care provider
- Individuals should be able to get a second opinion in cases of severe or chronic illness or surgery
- Individuals should be able to get general and specialist care as appropriate

Appendix 2: Responsiveness Survey Descriptions

Household Survey – In-person interview

Purpose:

Estimate household respondents' assessment of the responsiveness of:

- the health care unit they go to most often for care
- an inpatient facility they went to for non-emergency surgery in the last 12 months
- the overall health system.

Evaluate the questionnaire for consistency of interpretation using cognitive testing

Assess mode comparability with interviewer administered questionnaire.

Sample/Number of countries: 5000 or 10,000 households/country in10 countries

Data collection mode: In-person interview with a small subsample to be self-administered.

Domains:

- Reports on experience with care in outpatient and inpatient settings
- Ratings of experience with care
- Health state description
- Health state valuation
- Demographics
- Socio-economic information
- Rating health system on responsiveness
- Rankings of importance of responsiveness elements.

Household survey – Postal

Purpose: Estimate household respondent's assessment of the responsiveness of:

- the health care unit they go to most for care
- an outpatient unit they went for non-emergency surgery in the last 12 months
- the overall health system

Evaluate the process issues related to conducting a postal survey of this type.

Sample/Number of countries: 2000-3000 households/country in as many as 50 countries if feasible.

Data collection mode: Post

Domains:

- Reports on experience with care in outpatient and inpatient settings
- Ratings of experience with care
- Health state description
- Demographics
- Socio-economic information
- Rating health system on responsiveness
- Rankings of importance of responsiveness elements.

Appendix 2 (continued)

Facility survey

Purpose: Obtain information to compare to the respondent's report of care and data that will serve to help with analyses of respondent data by facility characteristics.

Sample/Number of countries: 300 facilities/country in as many of the 10 household survey countries

Data collection mode: In-person

Domains:

- Facility location
- Facility ownership, funding and management
- Staff size
- Patient load
- Bed capacity
- Physical characteristics relevant to responsiveness
- Procedures relevant to responsiveness
- Report of care experience at time of exit from the care unit.

Key informant survey

Purpose: Estimate of key informant (person knowledgeable about the health system) of responsiveness of health system

Sample/ Number of countries: 100/country, in as many countries as possible

Data collection mode: multiple (in-person/post/email)

Domains:

- Reports on experience with care in outpatient and inpatient settings
- Ratings of experience with care
- Demographics
- Rating health system on responsiveness
- Rankings of importance of responsiveness elements.